Foreword to The Becoming Safely Embodied Skills Manual

by Janina Fisher, PhD

Traumatic experience affects not only our minds, emotions, and systems of belief, but also the body. At the moment of life threat, 'animal brain' instincts take precedence over reflective decision-making, allowing us to run, duck for cover, hide, fight back, or "huddle and wait for it to be over"—whatever best helps us to survive. Decades after the mind knows that we are safe, the body still responds as if it were under life threat. Triggered by everyday normal life stimuli directly or indirectly reminiscent of the trauma, the same bodily responses are instinctively re-activated that originally helped us to survive. What was once an adaptive survival response has now become a symptom. The body that used its animal brain instincts to negotiate a dangerous world now feels like an enemy, rather than an ally. It is ironic that the very same responses that preserve our physical and psychological integrity under threat also drive the symptoms of post-traumatic stress for months or years after the events themselves (van der Kolk et al, 1997; Ogden, Minton & Pain, 2006). To make matters more challenging, the survivor of trauma is left with a mind and body that now function better under conditions of threat than conditions of calm, peacefulness, or pleasure.

With the advent of technology that allows us to study the brain and nervous system responding to stimuli, researchers have observed that narrative memories of traumatic events are connected to intense states of autonomic nervous system arousal (van der Kolk & Fisler, 1995). Even "thinking about thinking about" the memories is often enough to cause a reactivation of the nervous system as if the events were recurring right now, right here. Attempts to address the history of trauma through narrative therapy can quickly become complicated when the telling of the story evokes intense reactions that exacerbate the client's symptoms, rather than resolving them.

By the time the trauma survivor comes for group or individual treatment, the neurobiological and psychological effects of a hyperactivated nervous system and trauma-related emotional and attachment patterns have often become so well-entrenched and habitual that they now subjectively feel like "just who I am." The client has identified with the symptom, so that it is no longer the conveyor of a history that cannot be fully remembered or put into words: it is "me." In addition, other symptoms tend to have developed that represent valiant attempts to cope with the overwhelming physical and emotional experiences: self-injury and suicidality, shame and self-loathing, isolating, caretaking and self-sacrifice, re-victimization, and addictive behavior. All of these patterns represent different ways of modulating a dysregulated nervous system: self-injury and planning suicide induce adrenaline responses that increase feelings of calm and control; self-starvation and overeating each induce numbing; isolating allows avoidance of trauma-related stimuli; and addictive behaviors can induce either numbing or increased arousal or a combination of both.

In traditional psychotherapy models, it has always been assumed that, as a consequence of re-telling the story and re-experiencing the feelings connected to what happened, these trauma responses would remit naturally on their own. Clinical experience and recent neurobiological research tell a different story: the human mind and nervous system will always have a tendency to respond to a reminder of past threat as if it too were a threat unless the brain's frontal cortex is "on line" and therefore able to discriminate a real threat from the reminder. To actually desensitize or transform a traumatic memory, we need to change the mind-body responses to that memory: to reinstate activity in the frontal lobes so we can interpret the responses differently or react to them differently. We need to counteract the habitual responses by calling attention to them, providing psychoeducation about how and why they are symptoms, encouraging mindfulness and curiosity in place of reactivity, pacing the exploration of the past so that the autonomic nervous system can be better regulated instead of dysregulated by the recovery process, and by encouraging the developing of new responses to triggers or memories that compete with the old habitual responses.

We need to challenge the subjective perception of traumatized clients that the symptoms are just "who they are."

In 1998, when I first met Deirdre Fay as a colleague at the Trauma Center, an outpatient clinic and research center founded and directed by Bessel van der Kolk, she had been recently recruited as a staff member because of her many years of work in the yoga and mindfulness world. At that time, new research on the neuroscience of trauma had begun to yield findings that suggested that trauma treatment could not ignore the body in any form of effective treatment, and the Center needed a body specialist to help develop new approaches to trauma. When I first began sending clients to Deirdre Fay's "Becoming Safely Embodied" groups, I was simply hoping for the outcome all individual therapists do: that my clients find support and an opportunity to universalize their symptoms. I was unprepared for the immediate and dramatic changes in their capacity to engage in their individual therapies. Week after week, I observed that clients who were participating in the group were making gains at a rate far exceeding that of others. The client with whom I had talked ad infinitum about enmeshment with her nuclear family suddenly "got it" after a group focusing on boundaries using an experiential, rather than cognitive, approach. A client with a very long, painful history of early parental and sibling loss found unexpected comfort in a group devoted to the topic of belonging. A childlike, helplessly angry client developed skills that she began to use to modulate intense emotional and autonomic states, rather than drowning in them.

In ensuing years, I had the opportunity to learn the Becoming Safely Embodied model personally as a co-therapist in groups led by Deirdre Fay. As a result, I could come to appreciate the simplicity and creativity of this approach and eventually to urge Deirdre to publish her work so that it could be made available to other therapists and clients around the world. Deceptively simple, the model takes the essential ingredients of a trauma recovery program and breaks them down into small, achievable steps. Practice in mindful observation is needed, for instance, to challenge the automatic unthinking instinctual responses to traumatic triggers. Deliberate focus on cultivation of a sense of belonging can challenge habitual beliefs, such as"I don't belong" or "I don't matter to anyone." Cultivating the ability to step back from overwhelming experience to study its components (thoughts, feelings and body sensations) is essential to the skill of modulating autonomic activation. Identifying facts versus feelings and learning how to be "present in the present" help cultivate past-present differentiation. Without the ability to make those discriminations, clients continue to feel a sense of unending subjection to threat for decades after the traumatic events are over. Finally, learning to deliberately choose new responses or deliberately change one's perspective challenges beliefs that nothing will ever change, that the survivor is helpless in the face of the intense activation, overwhelming emotions, and beliefs that she is damaged and defective. I can still recall a client whose pessimism and conviction of her own and others' defects were suddenly transformed by the instruction to tell the same story from two different perspectives. One was the perspective I had come to anticipate: angry, bitter, hopeless, and painfully lonely. But the next story suddenly allowed her access to another world of possibilities: it was the same narrative told in an affirming, tender, emotionally moving way and filled with faith in the world of human beings. Without the experience of that exercise, she would still be expecting the worst, and the therapist would still be expecting her worst.

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REFERENCES

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